NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
ALTERNATIVE CREDENTIALING
DERMATOLOGY

Name of Licensee _____

License # _____

By this application I am seeking from the Board privileges, pursuant to N.J.A.C 13:35-4A.12, to enable me to perform the procedures indicated below. I understand that I may be asked to submit supporting data documenting training and experience to perform the procedures requested.

PRIVILEGE CRITERIA

Dermatological Procedures:
Demonstration of clinical experience, through an attestation as to the number and type of dermatological surgical procedures performed by the applicant, in the last two years with acceptable results for patients of all age groups, except as specifically excluded from practice, plus

(1) Current certification in dermatology granted by the American Board of Dermatology or the American Osteopathic Board of Dermatology or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in dermatology which provided specific training in cutaneous surgery, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ (any field which provided specific training in cutaneous surgery) **AND** active participation in examination process leading to certification in dermatology.

Procedures Requiring Additional Training:

Documentation of additional training specified below must be provided for each of the following procedures, if privileges are requested for these procedures:

- ☐ Complex repair of surgical defects, flaps and grafts,
- ☐ Mohs micrographic surgery

Completion of a training program **accredited by ACGME/AOA or other accreditation entity that is demonstrated by the applicant to have standards of comparable rigor** documenting training;

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OR

Documentation from the program director of an accredited residency training program **accredited by ACGME/AOA or other accreditation entity that is demonstrated by the applicant to have standards of comparable rigor** attesting to the training during residency in the **requested** procedure(s):

PLUS

Documentation from a privileged physician who has directly observed the applicant's successful performance or participation in the **requested** procedure(s).

Documentation of additional training specified below must be provided for the following procedure, if privileges are requested for this procedure:

☐ Liposuction - surgical specialty training necessary

Applicants with surgical specialty training provide:

1) Certification in a surgical specialty granted by the American Board of Medical Specialties ("ABMS") or the American Osteopathic Association ("AOA"); or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor; **OR**

2) Active participation in examination process leading to certification in a surgical **specialty; OR**

3) Successful completion of an ACGME/AOA accredited residency training program in a surgical specialty;

PLUS

1) Inclusion of, and successful completion of liposuction training in the course of instruction in the accredited surgical specialty training program;

Or

1) Completion a liposuction training course that is sponsored by an Accreditation Council for Continuing Medical Education (ACCME) or AOA accredited provider of Category I CME, including Category I providers accredited by their state medical societies through ACCME's state recognition program, and which provides at least three (3) hours of training in a bioskills cadaver laboratory and which also **meets the criteria for** a minimum of eight (8) hours of Category 1 **credit towards the Physician's Recognition Award of the American Medical Association or has been** approved by the American Osteopathic

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Association for a minimum of eight (8) credit hours of **Category 1** continuing medical education ("CME");

Record Review/Clinical Observation:

From the log provided by the applicant, at least 5 cases representative of the type of procedures **for which privileges are** requested will be selected **for provision by the applicant of patient records with personal identifiers redacted**.

_____

DELINEATION OF PRIVILEGES
INSTRUCTIONS: Check the column on the left to indicate those procedures you are intending to perform in the office setting.

Requested Privileges

_____ Complex repair of surgical defects, flaps, and grafts with anesthesia services - **Requires additional training**

_____ Liposuction - **Requires surgical specialty training**

Mohs micrographic surgery with anesthesia services- **Requires additional training.**

_____ Other - *Please specify procedure(s) and provide supporting documentation on separate page* .

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me and/or if the materials submitted by me are willfully false, I am subject to punishment.

_____ _____
Signature of Applicant Date

Application Tracking Record:

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested _____
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____

Licensee Name: _____ License Number: _____